

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED FEB 16 1942

Registration District No. 607

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3806

State File No.

Registrar's No.

3015

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Portageville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community  
years, months or days)

3. (a) PRINT  
FULL NAME

3. (b) If veteran,  
name war

3. (c) Social Security  
No.

4. Sex

5. Color or  
race

6. (a) Single, widowed, married,  
divorced

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month)

(Day)

(Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Portageville

(If outside city or town limits, write "RURAL")

(d) Street No. Wm. Lewis Store

(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 23

year 1941 hour 3 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from

Dec 9, 1941, to Dec 23, 1941

that I last saw him alive on Dec 13, 1941

and that death occurred on the date and hour stated above.

Immediate cause of death

Respiratory failure

14 days

Due to

Prematurity

Due to

all of mother

at birth

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations 159

Of autopsy

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)

(e) Means of injury

23. Signature Belmont (M. D. or other)

Address Portageville Mo Date signed 12-24-41

RECEIVED

District Health Office No. 2

District File Number 2-42-184

Date Filed 2-16-42

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*Not Embalmed*  
working under my personal supervision.

Registered Apprentice No.....

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.